First Steps

UTS TRAINING TIMES

Volume 8 Issue 4 November 2012

Inside this Issue…

- The Indiana First Steps Early Intervention Personnel Guide has been updated. The current version of the Personnel Guide is dated August 2012. This version of the Personnel Guide should be used for reference and credentialing forms. You may download a copy of the Personnel Guide at: https://www.infirststeps.com/UI/pdfs/First_Steps_Personnel_GuideRevised_8-2012.pdf. Questions related to the Personnel Guide should be forwarded to firststepsweb@fssa.in.gov.

- The Quality Review contractors have now completed several provider agency on-site reviews. These reviews focused on agency policies and procedures, agency training and supervision, credential files, face-to-face forms and progress reports. The agency reviews demonstrated a need for a training review on completion of the face-to-face forms and progress reports. Please direct any questions regarding completion of these forms to firststepsweb@fssa.in.gov. You may have noticed that the Directions for the Progress Reports was inadvertently deleted from the First Steps website. Until it is re-posted, you can find a copy on the UTS website under state forms at: http://www.utsprokids.org/firststepsinfo.asp.

- Special thanks to Tots N Tech at Arizona and Thomas Jefferson Universities for permission to reproduce their assistive technology newsletters. The October 2012 edition focuses on visual prompts for infants and toddlers.

- This month's Spotlight article features nutritional services. We are grateful to Trina Eastin, RD for contributing to the Spotlight series to provide you with information on nutrition services available in First Steps.

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INDIANA'S UNIFIED TRAINING SYSTEM

"Creating Learning Opportunities for Families and Providers Supporting Young Children"

First Steps Enrollment and Credential Training Requirements

Provider Level - New	Training for Enrollment	Training for Initial Credential
Service Coordinator (Intake and Ongoing)	SC 101—SC Modules (self-study)	SC 102 within 3-6 months of employment date SC 103 within 6-9 months of employment date Quarterly (4) - Training Times Assessment (self-study) First Steps Core Training—one course per credential year (self study or on-site) 15 points for initial credential
Direct Service Provider	First Steps Orientation or DSP 101—Provider Orientation Course (self-study)	***DSP 102 - within 60 days of enrollment (on-site)** ***DSP 103 - within 3-6 months of enrollment (on-site)** Quarterly (4) - Training Times Assessment (self-study) First Steps Core Training—one course per credential year (self study or on-site) 10 or 15 points for initial credential * timeline for completion has been revised, effective 07/12.
Provider Level - Credentialed	**Training for Enrollment**	**Training for Annual Credential**
Service Coordinator (Intake or Ongoing who has completed initial credential)	SC Orientation and Service Coordination Level 1 or SC 101 – SC Modules (self-study)	Quarterly (4) - Training Times Assessment (self-study) First Steps Core Training - one course per credential year (self study or on-site) 3 points for annual re-credential
Direct Service Provider (who has completed initial credential)	First Steps Orientation (on-site or self–study) or DSP 101 - Provider Orientation Course (self-study)	Quarterly (4) – Training Times Assessment (self-study) First Steps Core Training - one course per credential year (self study or on-site) 3 points for annual re-credential

Attention: New Providers and Service/Intake Coordinators

The Bureau of Child Development Services requires all providers and service coordinators to complete the quarterly *Training Times* assessment as part of your mandatory training requirements for credentialing.

New providers must establish an account on the UTS website (**http://www.utsprokids.org)** to register for UTS trainings**.** Obtaining an account is easy.

1. Click the Account Login in the upper right hand corner.
2. On the login page click on Create One Here
3. Enter your information (note that UTS Training Times is mailed to your primary address—you are encouraged to use your home address, especially if it is difficult to get personal mail at your workplace, e.g. hospital system). UTS does not give any of your training profile information to anyone outside of First Steps. The BCDS and UTS will periodically send you email updates regarding First Steps.
4. When all information has been entered click the Update Information.
5. Register for your annual training fee.
6. Once your payment has been posted, you can take the Training Times assessment, under My Quizzes.
7. If you have questions or encounter problems email Janice in the UTS Connect office at: **registration@utsprokids.org**

Indiana First Steps
UTS Training Times
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Web Address: http://www.utsprokids.org

Email: Training questions training@utsprokids.org

Registration questions: registration@utsprokids.org

Service Coordinator Training Dates for 2012-2013

Service Coordination 102: All service coordinators must enroll and complete SC 102 3- 6 months after employment date. If you are unable to adhere to this timeline, you must request a training waiver. Email your request to training@utsprokids.org.

Tuesdays at ProKids, Inc. Indianapolis from 9-4pm
11/13/12 2/12/13 5/4/13

Service Coordination 103: All service coordinators must complete SC103 6-9 months after employment date. If you are unable to adhere to this timeline, you must request a training waiver. Email your request to training@utsprokids.org.

Tuesdays at ProKids, Inc. Indianapolis from 9-4pm
12/5/12 3/12/13 6/11/13

All Service Coordinators must register online for SC 102 and SC 103 at **www.utsprokids.org** .

DSP 102 and DSP 103 Provider Follow Up Orientation

All newly enrolled providers must complete the DSP series 102 and 103 within the **first 6 months of their enrollment.** DSP 101 is required for provider enrollment. DSP 102 must be completed within 60 days of provider enrollment and DSP 103 must be completed three to six months following the enrollment date. Completion dates for these courses must be documented on the Annual Attestation Statement and initial credential. Training dates for DSP 102 & 103 are listed below. These trainings are held at ProKids Inc. Since there are specific timelines for completion of DSP 102 and DSP103 that allow time for experience in the First Steps System, providers may NOT take both courses on the same day.

DSP 102 Dates	Time	DSP 103 Dates	Time
November 6, 2012	1:00-4:00PM	November 6, 2012	9:00-12:00PM
December 11, 2012	1:00-4:00PM	December 11, 2012	9:00-12:00PM
January 8, 2013	1:00-4:00PM	January 8, 2013	9:00-12:00PM
February 5, 2013	1:00-4:00PM	February 5, 2013	9:00-12:00PM
March 5, 2013	1:00-4:00PM	March 5, 2013	9:00-12:00PM

AEPS 2-DAY Certification Course

This course provides a 2 day, comprehensive overview of the Assessment, Evaluation and Programming System (AEPS) for Infants and Children. The AEPS is a criterion-referenced developmental assessment tool for children, birth to six years. This course is required for all ED Team members. The 2-day AEPS course may also be used as a First Steps Core Training (FSCT) for your First Steps initial or annual credential. **Cost: $75**

January 24 & 25, 2013 April 4 & 5, 2013

Additional Opportunities for Credential Points

Providers may utilize trainings (on-site and self-study) and conferences/workshops outside of UTS to meet their initial or annual credential points as long as the training is related to the First Step core competencies and it is relevant to infants through age 3. These may include training offered at the SPOE Provider Meetings, provider agency training, association conferences (APTA, ASHA, etc.), hospital based conferences or grand rounds, other local, regional and national conferences, and books, videos and online training. You must keep a copy of the agenda or brochure that includes date, speakers, an agenda/content information with the time spent in the sessions you attended or a one page summary of the self-study training in your credential file. **Recent changes to First Steps credentialing allow a maximum of 5 points for in-service training, while conferences/workshop taken outside of provider agencies is unlimited.** More information on credentialing can be found in the recently revised Personnel Guide (August 2012) at

https://www.infirststeps.com/UI/pdfs/First_Steps_Personnel_GuideRevised_8-2012.pdf

ANNUAL TRAINING FEE DUE

All providers (with the exception of those exempted from credentialing) must register and pay their 2013 Annual Training Fee (ATF) online at http://www.utsprokids.org, by January 31, 2013. The ATF remains at $60 per provider. The ATF covers the cost of the provider's online Training Profile, the quarterly Training Times, and registration for one (1) First Steps Core Training (FSCT) annually. Remember if you are paying by check, money order or purchase order, you **must** include the confirmation number with your payment. This is necessary to insure that the correct account is credited. Agencies paying for multiple providers must include a confirmation number for each provider. Any payment received without a confirmation number will be returned to the sender.

- In 2013 you are required to complete one First Steps Core Training (FSCT) and four Training Times assessments (Winter, Spring, Summer and Fall). The calendar of available FSCTs is posted online. Additional FSCTs will be added throughout the training year. **Please note that you cannot complete the same course more than one time. Be sure to review your My Trainings tab before registering for this year's FSCT.**
- Providers must pay the ATF before registering for their FSCT. At the end of the ATF registration process you will receive a confirmation number. You may use this number in lieu of payment for your FSCT (there is a place to enter it on the payment page). **Each year's ATF may only be used once, and it can only be used for a training that has the FSCT designation in its title.**
- When registering for your FSCT you will have 3 payment choices: 1) Pay with ATF; 2) Pay with credit card; or 3) Pay with check or purchase order. If paying with the ATF, please make sure you are using the current year's confirmation number. For example, the 2013 ATF confirmation number can only be used for trainings that occur in 2013. If you click on credit card or check you will be charged for the training.
- Most trainings designated as FSCT can also be taken as topical trainings. If that is the case, you would pay the posted rate using a credit card or check.
- The BCDS has authorized the AEPS 2-Day Certification Course as a FSCT; however, the fee for this training is not covered by the ATF. Providers and Intake/Ongoing Service Coordinators who wish to use this course as their FSCT must pay the $75 fee. The ATF may be used to pay for another FSCT-designated training. Please note that the AEPS 2-Day Certification Course can only be used as a FSCT once and only in the year that it was completed.
- **Courses not eligible for FSCT** include SC 101, 102 & 103 and DSP 101, 102 & 103. There is a refresher DSP 101 course for "seasoned" Direct Service Providers. This course is clearly marked as a **Refresher** course and it includes **FSCT** in its title. Please note that the Refresher course **CANNOT** be used for your initial credential period.

Face-to-Face Form Review

All providers are required to complete a Face-to-Face form at every child/family visit. The Face-to-Face form serves not only to document the visit for billing purposes, it is a summary for parents, other providers and the service coordinator of the activities, progress, family involvement and training that occurred. The Face-to-Face form also serves as the basis for the development of the child progress form.

The Face-to-Face form on page 5 includes all required information and prompts to help improve the content written in the form. The Result of Visit section should include adequate documentation to support the amount of time spent with the child and family. Providers should also document when the quarterly progress report has been reviewed with the family.

Agency developed forms must include all items below, agencies may add fields, i.e., CPT or ICD9 codes.

Provider Contact and Agency Information

First Steps Service Provider

Face to Face

Child's Name: Full name as listed on the IFSP **Date:** month/day/year of service

Child ID#: 9 digit from IFSP **Service Start Time:** Exact* **Service End Time:** Exact *use am/pm or military

Location of Service: Note if not child's home - always use complete address, where service was provided

Street address City Zip

IFSP Outcome to be addressed: Include # and paraphrase IFSP outcome, list all outcomes you addressed

Results of Visit: 1. What skills were targeted? 2. What activities were used? 3. How much assistance was provided? 4. Was progress made? If yes, describe. If no, what are barriers to progress?
Use objective information, # of trials, # feet walked, sounds produced, new words/signs, what is child able to do as a result of this visit or from work between visits, etc.
Activities and progress should vary week to week.
Activities should be reflective of time spent with child/family.
Use this area to document when the progress report has been discussed with the family.

Follow-up Needed: List anything that any team member (parent, SC, provider) needs to do. May include specific activities for parent/caregiver to do between sessions. If none, note NA.

Family Education/involvement: Who was present for the session (mom, dad, relative, child care teacher, etc). Were they present the entire session? How did they participate? How knowledgeable were they about child's progress? When activities are suggested do they follow up? What training was provided to them at this session? If family not present, how will this information be relayed to them?

Next Scheduled Session: specify day, date, time and location of next session

Day Date Time Location

Please note if there has been any cancelled sessions (and not rescheduled) in between this visit and your last visit.

Yes, the provider needed to cancel the session scheduled for _____. *include why - needed for progress note
Date

Yes, I (the parent) needed to cancel the last session scheduled for _____. **also include appt. no shows
Date

My signature certifies that the activities identified above occurred at the time and location indicated and that 1, 2 **minutes/hour of direct service were provided to my child/family.**

Parent or caregiver signature is required for billing 3

Parent Signature **Date** **Telephone**

Provider signature is required for billing

Provider Signature **Date** **Telephone**

Note: The parent is to be provided with a copy of the completed form.

1. Time should be exact and must match time in and out.
2. Do not round up, units are in 15 minute increments. less than15 minutes, must round down
3. If parent did not sign, must obtain a late signature within 5 days of the service date and note date that signature was obtained.

First Steps Progress Report

Child Name: **FS ID#:** **DOB:** **IFSP Date:**

CHILD INFORMATION:

Chronological Age: **Adjusted Age (if applicable):**

Primary Diagnosis:

ICD9 code: **Onset Date:**

Precautions/Contraindications:

Primary Care Physician:

PCP Phone #: **PCP Fax #:**

Report Date:

Report Type:

- ☐ 3 Month
- ☐ 6 Month
- ☐ 9 Month
- ☐ Annual
- ☐ Discharge
- ☐ Other

FAMILY INFORMATION:

Parent /Guardian Name:

Address:

Phone: **Email:**

Primary language:

IFSP TEAM INFORMATION:

Discipline	Provider Name	Phone	E-mail
Service Coordinator			
ED Team Contact			
EIS			
EIS			
EIS			
EIS			
EIS			

- **Child name, First Steps ID# and date of birth** must match IFSP and PAM system.
- **IFSP date** should be for the current IFSP and must be updated after the annual IFSP.
- **Report date** is date report was completed.
- **Report type** - check box for appropriate period (you may check more than one, i.e., 9 month and discharge)
- **Chronological age** should be age when report was written. **Adjusted age,** if applicable (more than 4 weeks premature and less than 2 years of age).
- **Primary diagnosis** and **ICD9 codes** are from PHS, IFSP page 2 or any additional diagnoses received from the physician. The primary diagnosis is different than the Treating Condition found under Current IFSP EI Services section.
- **Onset date** - child's birth date or a later date when the parent/MD became aware of condition. Obtain date from family.
- **Precautions/Contraindications** - special measures/modifications taken because of the child's condition, usually reported by physician. You can include food and contact allergies here, i.e., Allergic to peanuts and latex
- **Family Information** - check for accuracy and update as needed. When changed or updated note **new,* next to the change.
- **IFSP Team information** - check for accuracy and update as needed. All IFSP teams should designate a lead provider. Determining who is lead is based on agency policy. Ideally the lead provider is listed first or there is some other indication of who is lead, i.e., EIS PT **lead*, in the first column.

CURRENT IFSP EARLY INTERVENTION SERVICES:

EARLY INTERVENTION SERVICE	Start of Service Date for Current Authorization	Treating Condition with ICD9	Frequency (times per week/mo)	Session Length (# minutes)	Authorization Period (start/end dates of auth)

- **EIS** in column one should auto fill from IFSP Team information.
- **Start of service date for current authorization** is the first date of service when the child was seen for the current 3 month authorization. This date will change for each progress report.
- **Treating condition with ICD9** - list the name of the condition being treated for each discipline. Developmental Therapists should use the primary diagnosis found on page 2 of the IFSP or from the PHS. Other disciplines, including OTs, PTs & SLPs must determine their treatment code based on their practice acts and/or information from the child's physician. The treating condition is almost always different from the primary diagnosis. For example, a therapist does not treat Down Syndrome, he/she is treating a condition related to Down Syndrome (758.0), such as hypotonia (781.3), feeding difficulties (783.3) or language delay (315.39). Codes are determined individually by the provider of the service. While treating conditions and codes cannot be prescribed by the state or an agency, the agency is responsible for ensuring that correct and appropriate ICD9 treating condition codes are used for billing services. If more than one treating condition codes are used, list the most appropriate first. This code should be used for claims, as the PAM system will accept only one ICD9 code. Providers should receive training from their agencies on the use of appropriate treatment codes.
- **Frequency and session length** can be found on the service page of the IFSP or the change page. These must be from the most current authorization.
- **Authorization period** - list the start and end dates for the current period.

SESSION ATTENDANCE:

EARLY INTERVENTION SERVICE	# Sessions completed for this period	# Provider cancelled sessions	# Family cancelled sessions	Reasons for each cancellation

*Reasons **F** family illness; **P** provider illness; **FS** family schedule conflict; **PS** provider schedule conflict; **FNS** family no show; **FO** family other reason- describe in narrative; **PO** provider other- describe in narrative*

- The session attendance provides a snapshot of the sessions that were completed or missed because of provider or family reasons. Information for this section of the progress report should come directly from the face-to-face sheets for the current report period.
- The Early Intervention Service (EIS) will auto fill from the IFSP Team Member section. For each EIS, the provider should list the actual number of sessions completed from the last report to this report date*. The provider should not count sessions that have not yet occurred. *Progress report directions advised listing number of sessions for the authorization period, but since reports are completed 30 days before the authorization expires, using report date to report date provides a more complete picture.
- The provider enters the number of provider cancelled or missed sessions and using the key provided, note the reason for each missed session.
- The provide enters the number of family cancelled or missed sessions and using the key provided, note the reason for each missed session.
- Information contained in this section can be useful when discussing progress or lack thereof and in making recommendations for future services. When patterns are noted, (i.e., a family frequently cancels on only one provider), the team should use this information to discuss possible causes and solutions. Does the parent value this provider or service? Is the appointment time a barrier? Is there a personality conflict between the parent and provider? Is the child making progress, even though he/she is receiving less than authorized services?

First Steps Progress Report

Child Name: **Report Date:**

IFSP OUTCOME REVIEW:
Outcome # :

Long-Term Goal(s):

- There are 5 versions of the Progress Report form (one, two three, four and additional outcomes).
- Choose the correct progress form based on the number of outcomes in the child's current IFSP.
- Type in the Outcome # in the space provided (before the colon). After the colon type the Outcome as written in the IFSP.
- All providers who are responsible for working on this outcome need to contribute to the Long Term Goal (LTG). More than one LTG can be written if different providers have different LTGs for the same outcome. **LTGs are set by the service providers and must relate to the IFSP Outcome set by the IFSP team,** including the parent and service coordinator. Providers may use the additional outcome form, if more space is needed for LTGs.
- LTGs should be measurable and are used by the IFSP team to determine if the child has met the outcome.
- When a LTG has been achieved, but the IFSP Outcome is not met, providers should develop new LTGs. These can be included in the comment section. On the subsequent quarterly report, you can delete the achieved LTG and add

STG # :			
Date Set:	Set by:	Expected Achievement Date:	Status Code:

STG Status Codes: A=Achieved; P=Partially Met (continue); NP=No progress (continue); D=Discontinue

- Each therapist working on an outcome and LTG is responsible for developing their own STGs (short term goals).
- Each STG should be assigned a number and also include a narrative statement. There are spaces for 5 STGs for each outcome. If there are more than 5 STGs for an outcome providers should use the additional outcome form.
- STGs must be developed within the first few weeks of service. Providers should talk with the parent as these STGs are developed, modified, discontinued and/or achieved. **STGs must relate to the LTGs and IFSP Outcome.**
- STGs need to be measurable (i.e., child will do a specific action that can be seen or heard, such as # or % of successful trials for a specific skill, length walked, new words or increased intelligibility of words, etc.).
- The print space for STGs is limited. Characters exceeding the limit will not be visible on the printed form. You may adjust text size.
- Note the date you set the STG.
- Since providers are responsible for setting their own STG, you must include your name and discipline here. This way everyone reading the progress note knows who set and is working towards this goal. **You should not state that the STG was set by the IFSP team or EDT.** STGs should not be confused with the IFSP progress markers found on the IFSP outcome page. These are included as part of IFSP planning. You, as a provider may choose to develop a STG that is similar to one or more of these progress markers, but you would need to modify it to make it measurable and identify it as set by you.
- Expected date of achievement is when you expect the STG to be fully achieved. Realistically this should be within the IFSP timeframe, ideally within the next 3-6 months.
- When reporting on STGs you need to use the codes provided on the bottom of the page (A=achieved, P=partially met, NP=no progress or D=discontinue). When STGs show no progress or very limited progress, the provider in collaboration with the IFSP team should consider changes or modifications to the STG and or IFSP services.
- STGs that are achieved can be dropped on subsequent progress notes.
- When the STG has been achieved, but the LTG and Outcome have not been achieved, you will need to identify new STGs. These should be included in the Comment section and then added as a STG for the next progress period. The team should also consider if the child has made sufficient progress to warrant a decrease in services.

Baseline:

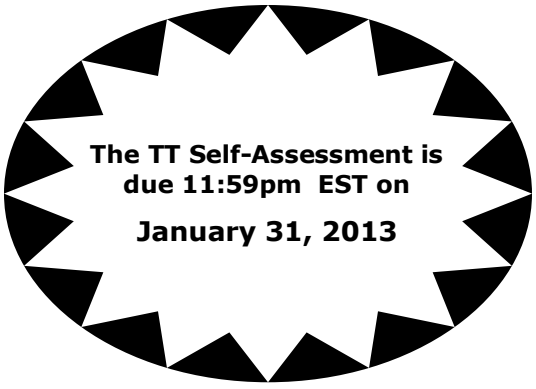
Baseline should provide a detailed picture of the child level of performance related to the STG, at the time the STG was set. **The baseline does not change once is it established and remains the same until the STG is achieved or discontinued and removed from the progress report.** The baseline provides a starting point from which progress for the STG is measured.

Current Level:

The current level of performance is both qualitative and quantitative. It should include a detailed description of the child's current level of performance related to the STG, including data related to the measures identified in the STG. For example, if the STG was to use 4 action words to express a desire, then the current level of performance should identify how many new actions words the child used, the appropriateness of their use, intelligibility of the words, etc. If STG was to take 10 steps without assistance from a person or object, then state number of steps child took per several trials, what assistance was required, describe the child's balance, gait, motivating factors, gait pattern, etc. In addition to what child is currently doing, you should mention skills that are emerging.

Other Comments, including new STGs (if applicable):

Providers should utilize this space to continue anything that did not fit into the appropriate space above or to add new STGs just set that will be reported in the next progress report. You can also add other information that pertains to the outcome, LTG or STG. You can also discuss any information related to the outcome that affects other people, i.e., child-care teacher and parent, another therapist collaborating on the same outcome, therapists co-treating or consulting.



TEAM DISCUSSION:

Summary of IFSP Team Collaboration:

Explain how your team communicated and collaborated during this quarter. Did you meet face to face, by phone consultations, emails, messaging, etc.? Was there a specific need or strategy that was discussed by the team? What decisions or plans came from these discussions?

Summary of Family/Caregiver Participation and Family Information Updates:

For each service provided, explain how the family or caregiver participated in therapy. Who was present for the visits? Were they present for the entire session? Did they leave room? Were they just observers? Were they active in working with the child? Was the parent or caregiver aware of child's progress? Do they work with the child between sessions?

This is the area to include family update information, changes in address, phone, marriage, new baby, etc. Any information that would be helpful to other providers and the SC.

New Outcomes to be Considered:

This is your opportunity to offer suggestions for new IFSP Outcomes. Providers can attend IFSP meetings or provide input regarding potential outcomes to be considered at the next IFSP meeting. Information included in this section serves only as recommendations. Outcomes are determined at the IFSP meeting, with input from the IFSP team, including the service coordinator and parents.

Suggestions for IFSP Service Modifications/Parent Resources:

Perhaps this child's service providers feel that the current IFSP could benefit from modifications prior to the next regularly scheduled IFSP meeting. These suggestions can be made for any IFSP service intensity, frequency or discipline, including plans for discharging a service, and/or requesting co-treatment or consultative services.

This section is also used to list parent resources provided or that would be beneficial to the family.

SERVICE RECOMMENDATIONS FOR NEXT AUTHORIZATION PERIOD – Pending review and consensus agreement of the IFSP Team:

EIS	Frequency (times per week/mo)	Session Length (# minutes)	Is this a change to current auth? Y/N	Additional Comments/Justification

Service authorizations are reviewed and rewritten approximately every 3 months based on the information provided in the progress report. In this section, the team has the opportunity to suggest a continuation in service frequency, intensity and discipline or they may recommend changes in service frequency, intensity or discipline.

The EIS (discipline) is listed with the recommended frequency (times per week/month/quarter) and intensity (length of the session). The provider should identify if this is a change from the current authorization and include comments and/or justification for the continued service or recommended service.

My signature below certifies that I have participated in the development of this team progress report (May use electronic signature if agency has Electronic Signature Policy on file with BCDS).

Signature & Title Date

The progress report must be signed and dated by each authorized ongoing service provider on the IFSP. If a provider is required to have a supervisor's signature on the progress report, then the supervising therapist must also sign this page.

If agency has an approved electronic signature policy on file, they may utilize an electronic signature. If the agency does not have an approved electronic signature policy on file with the state, then it must have procedures to insure that original signatures are obtained and maintained at the provider agency.

Don't forget to review the Progress Report with the family

Providers must review their portion of the Progress Report with the family on the next visit following the report date. Providers should work within their agency to determine how the family will receive a full copy of the report if more than one provider is on the child's IFSP. Service Coordinators check with the family each quarter to make sure that providers have discussed the report with the family and that they have received a copy of the full report.

It's Almost Flu Season

Have you gotten your flu vaccine, yet? As a home visitor you can lessen the spread of influenza and keep your family healthy by getting a flu vaccine. It typically takes 3-6 weeks to develop full immunity. It is a myth that the flu shot can cause the flu. The influenza viruses contained in the flu shot are inactivated (killed), which means they cannot cause infection. Flu vaccine manufacturers kill the viruses used in the vaccine during the process of making vaccine, and batches of flu vaccine are tested to make sure they are safe. The flu vaccine is typically contraindicated for those who have an egg allergy, a serious reaction to a flu shot, a history of Guillain Barre` Syndrome, or are currently ill with a fever. If unsure, always consult with your primary care provider.

Provider Spotlight - Nutrition Services

By Trina Eastin, RD, owner of Dietary Solutions of Indiana. A First Steps provider serving the Indianapolis metropolitan area since 2001, Trina works with infants and toddlers who have failure to thrive, feeding tubes, Down Syndrome, food allergies/intolerances, autism, dysphasia, and general feeding difficulties.

Who can provide Nutrition Services through First Steps?

According to the Indiana First Steps Personnel Guide, a Nutritionist must possess a Bachelor's, Master's &/or Doctorate degree and be certified as a Registered Dietitian by the Indiana Professional Licensing Agency, Dietitian's Board. To become a Registered Dietitian, one must complete at least a Bachelor's degree in Dietetics and a year internship through an approved hospital or University program. Once completed, a registration exam needs to be passed to obtain the credential of a Registered Dietitian (RD). To clarify a question often asked, in general a Registered Dietitian and Nutritionist are not always synonymous terms as anyone can refer to themselves as a "Nutritionist", however in the First Steps program these terms are one in the same and all First Steps Nutritionists are qualified, credentialed nutrition specialists.

What services do First Steps Nutritionists provide?

A First Steps Nutritionist is a member of the IFSP team to ensure that the child is well-nourished so that they can have their basic needs met to develop optimally. If a child's basic nutritional needs are not met then they may not have the energy to discover and learn and could have difficulty progressing in areas of motor and cognitive developments. Therefore, a First Steps Nutritionist can provide families the expertise and knowledge on how to provide appropriate nutrition for their child. This is done by doing an initial evaluation to assess the nutritional status of the child and their diet. Depending on the results, the First Steps Nutritionist can develop a plan to ensure that the child is getting all necessary nutrition to grow and develop appropriately. In most instances this will be done by educating the parent/caregiver in what foods and/or supplements are needed to help make the child's diet adequate. This is done by:

- working with the family on ways to offer foods to increase the child's acceptance
- developing child specific meal plans
- developing menus
- researching and exploring new foods/supplements for the child to try
- exploring new ways to offer foods

Most of the time is spent working with the parent/caregiver as they are the ones who are providing the meals, however as the child gets older some food activities can be incorporated into sessions to make eating fun.

When should a child be referred to a First Steps Nutritionist?

Once a child is found eligible for the First Steps program, the child and family may receive Nutrition Services when there is an identified need related to nutrition, such as:

- overall feeding concerns
- difficulty with progression to solid foods
- weight gain, affecting development (either too little or too much)
- refusing to eat foods from all food groups
- weaning off a feeding tube to oral eating
- food allergies/intolerances/aversions
- diet lacking sufficient calories, protein and nutrients to support the energy needed to progress with developmental skills

All of these circumstances can affect a child's nutritional status which could ultimately delay their progress developmentally.

Who would benefit from Nutrition Services?

Any child who is:

- having feeding difficulties such as transitioning from bottle/breast/tube feeding to eating food and drinking from cup
- allergic to certain foods, making it difficult for the parent to know what to feed the child
- not gaining weight &/or is losing weight
- gaining too much, and weight is interfering with mobility and developmental skills

Any member of the IFSP team, including the parent, service coordinator, provider or EDT member can make a request for a Nutritionist if they have concerns about the child's eating and nutrition.

How does a First Steps Nutritionist collaborate with other IFSP team members?

A Nutritionist collaborates in the same ways as other EI providers: via phone, co-treats, email, reviewing other therapists' Face-to Face reports and communication notebooks in certain situations. The most appropriate providers that a Nutritionist consults with on a regular basis are Speech & Language Pathologists and Occupational Therapists as they are the ones that most often work on feeding. However, it is always appropriate to consult and collaborate with all other team members.

How can Clusters locate a Nutritionist to provide First Steps Services?

A Cluster can contact the local Agencies to inquire about their list of dietitians that provide services in their area. As mentioned in the previous Social Work article in the last Training Times, the numbers of providers are fairly limited especially in the more rural areas, which is certainly a challenge. The local professional Indiana Dietetic Association could provide a list of dietitians at ida_exec@eatrightin.org , with pediatric experience or as a Pediatric Dietitian. Once recruited, the dietitian would need to complete the required First Steps enrollment and training.

Greetings!

It's WeeHands iPhone App Time!

Wow, we are ready to test the new WeeHands iPhone app! We are looking for 50 testers to help us find any 'bugs' and 'kinks'. Would you like to help?

We are looking for very social testers who have, or work with, young children. Approved testers will be invited to upload the new WeeHands iPhone app free of charge and to provide their feedback.

Thank you to all who apply! **Click here to apply!** Sara Bingham, WeeHands Founder (posted 10/19/12)

DDRS publishes quarterly updates and other notices on its webpage, including information about First Steps. You can sign up to receive DDRS announcements at https://public.govdelivery.com/accounts/INSTATE/subscriber/new

Thomas Jefferson University

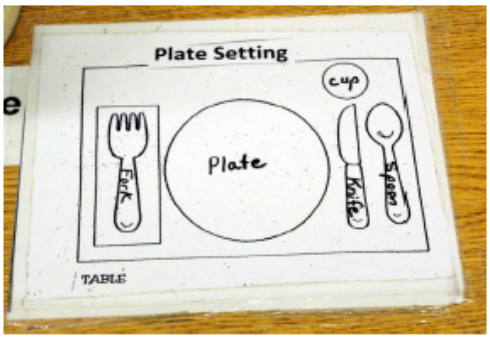
October 2012

Arizona State University

E-Newsletter

Using Visual Supports with Infants and Toddlers

Visual supports are a form of adaptation that rely on visual cues to allow infants and toddlers, and older children, to participate in activities and routines. Because infants and toddlers may find it difficult to communicate using words, visual supports can provide them with a system for communication while also teaching them important daily activities and routines. Visual supports provide supplemental information, cues, and directions to children who may communicate with behavior or are unable to read.



This newsletter will take visual supports that have been used successfully in childcare centers and preschools and show how they can be used in the home with younger children. As you will see, visual supports can be inexpensive to make and are applicable to many different daily activities and routines in all different environments!

What are Visual Supports?

Visual supports are graphic cues that can be used to aid communication between parents and children or as an environmental prompt that helps children remember what is expected of them in a certain activity or routine. Visual supports take many different forms and have various uses. They may be used to:

- Prevent challenging behavior & support social competence
- Support communication
- Enhance memory
- Provide a reference for previous directions
- Identify expectations for children within activities and routines
- Serve as a cue for new skills

In This Issue

What are Visual Supports? (Continued)

Because visual supports are useful in so many varied capacities, they may be used with both typically developing children and children with disabilities. As children become more familiar with the roles visual supports play in routines and activities, the supports themselves can become a stand-in for parents or providers assisting the child and will help the child develop self-monitoring behaviors. Eventually young children will stop using these visual supports naturally; parents will not need to worry about children becoming dependent on the support or needing to phase them out of a routine.

A visual support can range from something as simple as an egg timer acting as a signal to a child when their time in one activity will end, to something that requires more work, such as an individualized social story to provide a child with reference to what is happening in their environment. For instance, in the photo on the right a rather simple visual support is used. Teachers in a daycare center found that children were stomping on the lever of the trashcan to make the lid rise and fall. If they did not push hard enough the children would use their hands to lift the lid the rest of the way. After telling the children that they were getting germs on their hands by touching the trashcan, teachers noticed that the children continued to touch the lid. After adding drawings of germs to the lid of the trashcan to remind children of what they had been told before, teachers noticed that children stopped touching the trashcan lid.

Deciding Which Type of Visual Support to Use

Before sitting down to make a visual support for a young child, it is important to consider the child's needs for supports. That is, how well does the child participate when compared to your expectations? Then decide what your goals are for the child. This will help you focus on the specific things you will need to do to change the situation. Next, consider your options. Would a social story be a better solution to help the child deal with transitions than a first then board?

After selecting which visual support seems right, the next step is to determine what visual cues will be most useful. For most infants and toddlers, either objects or real life photos will be helpful cues. For example, actual objects and items may be used as a means to communicate. For example, when preparing for story time, Malachi's mother holds up two books, allowing him to choose which he would like to read. When children are responsive to photos, real photographs may be used to communicate. In this instance, Annie's mother shows her a photo of cereal or eggs so that Annie may choose what she would like to eat for breakfast.

Types of Visual Support

Social Stories

Social stories give children a personalized reference that provides comfort and assists in memory development and self-regulation. These personalized books tell a story of a specific occurrence and help the child understand what is expected of them in that situation without providing a definite script. In addition to providing expectations, social stories may highlight others' emotions or opinions, provide behavioral choices to the child, and highlight commonly shared values within the culture. Social stories should reassure the child and provide information about challenging activities. After being used enough, social stories may start to act as scripts to help children organize and interpret daily events. It is important that the stories are worded in a way that emphasizes what is expected — what should happen — rather than what is actually occurring. Social stories may be made for any situation. Jackson's mother made him a book to help him learn how to use the potty.

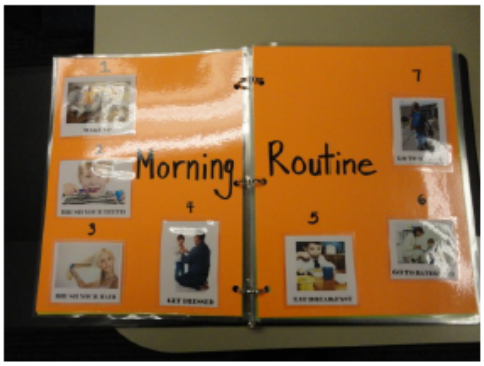
Example: Jackson has trouble remembering to use the potty when he needs it. To help teach him the steps to using the potty, Jackson's home-based teacher created a social story that describes the situation (*I am learning how to use the potty!*), refers to his mother's feelings when he uses the potty (*Mommy feels proud when I use the potty all by myself*), provides him with different ways to behave (*I flush the potty when I am done. Then I wash my hands with soap and water*), and highlights a commonly shared value (*I feel so happy after going potty all by myself!*). Jackson's mother read the social story to him each time she dressed him in his big boy underwear. Over time Jackson began telling his mother when he needed to use the potty and learned how to do it all by himself!

MAKE IT!

When writing the story, use descriptive statements to give details that may be applied to the child's environment. Take photos of the child participating in the activity to use as a backdrop for your social story and put them beside each statement. Be sure to have faces for each emotion you detail in the story so that the child can identify with others. To make a storybook put each statement and accompanying picture on its own page. Then punch a hole in the top left corner and tie together with ribbon or binder ring. Keep the social story book in a convenient place (in the above example, it could be the bathroom or bedroom).

Types of Visual Support (Continued)

Visual Schedules



Visual schedules lay out the events of a day or routine one by one for children. They give children a clear sense of the sequence and expectations of the day. Visual schedules may take many forms: specific or general, listing the events horizontally or vertically, removing events as they are complete or moving an arrow to identify the event presently occurring. In the photo on the left, each page in a binder represents a different routine. For the morning routine, first the child wakes up, then brushes teeth, then brushes hair, etc. As activities and routines are completed on the visual schedule, the pictures may be removed and put into a small envelope or other storage container so that the child knows those activities are completed. Remaining pictures show what is coming rather than what has already happened.

Example: Toya had trouble keeping on task and was fussy when transitioning between activities and routines. To teach Toya the order of the day's events, her father created a visual schedule to hang in her playroom. The schedule began with her morning routine and followed all the way through to her bedtime routine. Toya and her father went over the visual schedule every day so that she could learn to anticipate the activities that were coming and understand the expectations that came with them. Over time Toya's challenging behavior stopped and her father found it much easier to help her with transitions throughout the day.

When one part of an activity or a routine is challenging for a child, for instance tooth brushing, the visual schedule may be further broken down to detail that specific part. If Toya is having trouble remembering how to brush her teeth, her father might place a detailed visual schedule for tooth brushing next to the bathroom sink for Toya to consult during her bedtime routine.

MAKE IT!

First, determine how specific of a visual schedule is needed. Multiple schedule boards may be made when the child needs things to be very specific. Then, you'll be able to bring out a different board for each segment of the day (ex. morning, afternoon, night). Decide if you'd like your schedule to be vertical or horizontally oriented, then add Velcro to the board. Put a photo and description of each activity onto a card. Make sure all the cards are the same size so they can be moved if there are any changes to your schedule! Create a pocket at the bottom of the board for the cards if you would like to remove them as they are completed. Put the schedule at your child's eye level and teach them how to consult and use it.

Types of Visual Support (Continued)

First Then Boards

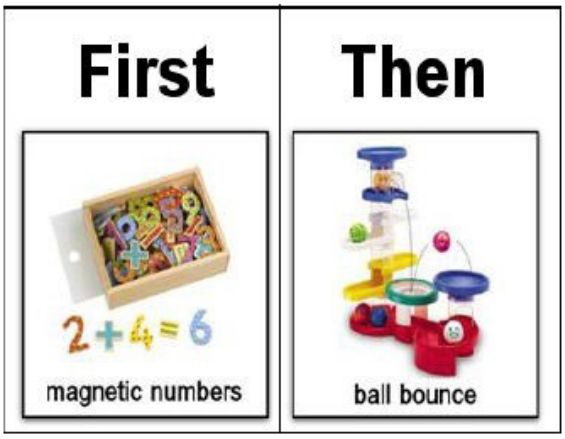


Photo credit: http://ips4specialkids.com/2011/08/10/first-work-then-play/

First then boards are similar to visual schedules in that they also list a sequence of events. A big difference between the two, though, is that first then boards teach children that in order to get a reward they sometimes need to do a less favorable activity first. As can be seen in the photo on the right, the board shows a picture of an unfavorable task on the "first" side and shows a picture of a favorable task on the "then" side. It is important to keep the words for each activity simple. The activity on the "then" side should always be reinforcing to the child. In this instance the board would be read to the child as "First magnetic numbers, then ball bounce." For infants and toddlers it is recommended that first then boards contain only 2 activities although they can contain more than one activity on the "first" side for older children. Children can also be involved in the process of choosing their reinforcing activity by presenting them with options for what they would like to do (choice boards—page 7).

Example: Jerome threw a tantrum every time his grandmother tried to put him down for a nap. His grandmother created a first then board to help Jerome understand that after his nap, something he enjoyed would follow. She made multiple cards with photos and names of rewarding activities and used them interchangeably on the "then" side of the board to remind Jerome that after the activity that he found unpleasant, a rewarding activity, such as playing outside or reading a book, would immediately follow. He learned to make the connection and his tantrums during naptime were significantly lessened.

MAKE IT!

Draw a thick, dark line dividing a board into two sides. Label the left side of the board "First" and the right side "Then." Place Velcro on each side of the line for the activity cards to stick to. Take photos of different reinforcing activities and challenging activities and place them on separate cards. Be sure to label each activity on its corresponding card so that your child learns the names of the activities. If your child has trouble following the first then board try using different activities on the "then" side. It is possible that your child may find some activities more reinforcing than others!

Types of Visual Support (Continued)

Contingency Maps

Contingency maps depict the antecedent-behavior-consequence (ABC) relationship for children's behavior. They are particularly helpful when children have shown challenging behavior in certain activities or routines. Contingency maps teach children what will happen when he or she engages in that challenging behavior. However, they also show what will happen if the child does not engage in the negative behavior, but instead engages in a positive but functionally equivalent behavior. In the picture, the contingency map is read as "If I take a nap, I get playtime but if I don't listen, I will not be able to play after nap." The contingency map clearly outlines the antecedent, behavior, and consequences of the child's actions. The consequence of the positive behavior should be reinforcing for the child, much like on first then boards. The consequence of the negative behavior should be the absence of the reinforcing behavior that was previously stated.

Example: Carlos refused to sleep at naptime. His mother created a contingency map to help him understand that he would have to listen and nap during naptime in order to play afterwards. She took photos of him sleeping peacefully, throwing a tantrum, playing, and sitting in timeout. Carlos' mother posted the contingency map next to his bed and reviewed

MAKE IT!

On a large board place Velcro about halfway down on the left side, then 3 more pieces each of Velcro across the top and bottom. Draw arrows connecting the left to the upper and lower Velcro sections, plus signs between the first two pieces of Velcro, and equal signs between the last two pieces of Velcro. Then, make cards detailing what leads up to your child's challenging behavior, the challenging behavior itself, and the consequence of that behavior. Also make cards that provide your child with positive, but functionally equivalent, behaviors and the rewards you plan on providing for them. If your child exhibits multiple challenging behaviors make cards for each of them.

Types of Visual Support (Continued)

Choice Boards

Choice boards provide children with different options of what they would like to do within activities and routines. In the photo to the right, a child may choose between playing with Mr. Potato Head, using blocks, painting, or dancing. To prevent children from confusing the choice board with a visual schedule it can be helpful to arrange the choices in a shape rather than a line. Choice boards help children focus on appropriate options while giving them the opportunity to communicate what they would like to do, either verbally or by pointing, depending on functional level. Infants and toddlers should be given few options at first to learn the purpose of choice boards and prevent confusion. Simple phrases may be used to prompt the child to make a choice and the choice board can be used across many settings.

Photo credit: http://kickert.info/beth/2012/03/10/toodles-activity-board-from-mickey-mouse-clubhouse/

Example: David is preverbal and unable to communicate through words which objects he wants to use during playtime and gets frustrated when he is not understood. His father created a choice board to help him communicate which toys he wants to use. He makes sure that the choices are always different so that David will not get bored. After learning to point to the toys he would like to play with and working with his speech therapist, David has started to make sounds while pointing. His choice board has helped with his communication both verbally and physically.

MAKE IT!

On a large board place multiple pieces of Velcro in any shape (i.e., not in a line). Be sure not to give too many options so that your child will not feel overwhelmed. Make cards with photos and labels of different activities that can happen within a routine for your child. For example, if you are making a choice board for snack time put pictures of different foods, like an apple or crackers. Attach the cards onto the board in different places each time you use the choice board with your child.

The choice board can easily be used as a feelings board, too! Make cards with different emotions and faces to have your child tell you how he or she feeling. Then have your child act out the emotions into a mirror.

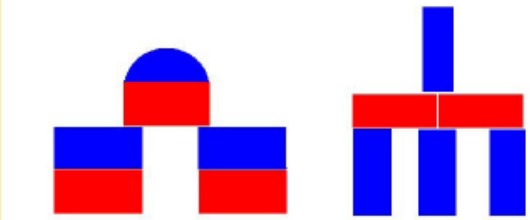
Types of Visual Support (Continued)

Other Types of Visual Support

Timer: You can signal to a child how much time is left in an activity or routine by using a timer with an easy-to-read face. The timer to the right changes from green to yellow when it is almost time to switch from one activity to the next. When it is time for a new activity or routine the timer will turn red. Timers may be used in conjunction with first then boards or visual schedules.

Stop Signs: Stop signs are be placed on doors to remind children not to run outside or to signal to children that a certain room is off limits. Smaller versions of stop signs may also be used on objects or places that may pose a danger to children, such as a stove or stairway.

Cues for Toys: Providing children with visual cues can give direction on what to do with an object within an activity or routine. For instance, on the right, instead of throwing blocks or using them in an inappropriate way, this picture cues a child about what to build with blocks.



Cue Cards: Cue cards are an easily transportable visual support for use in a variety of settings. They can serve as a visual schedule if read in a particular order or can be used as choice cards. They can be attached to a keychain, like those pictured, or attached as a necklace, or a zipper pull for easy access.

USING VISUAL SUPPORTS DURING Transitions

Transitions from one activity to the next can be difficult for most children. They involve sometimes unpredictable situations to which children react negatively. Social stories can help explain to children what everyone involved will be doing in the next activity, visual schedules can help lay out upcoming sequences of events, first then boards can ensure that children know what activity will come immediately after, and timers can alert children as to when the transition is coming. But what if none of these visual supports work?

- Suggestion 1: Who What Where When Why How

To prepare a child for a transition, a board can be created with the 6 classic questions, who, what, where, when, why, and how. The cards used should provide specific answers. In the case of getting ready to leave home for a community outing: *Who is going with me?* Dad is going with me. *What am I doing next?* Next we are leaving home. *Where am I going?* We are going to the grocery store. *When will I be doing it?* We will be going to the grocery store after naptime. *Why am I doing it?* We are going to the grocery store to buy food. *How will I get there?* We will take the bus to the grocery store. The who what where when why how strategy can also be used on cue cards to remind the child what is happening while on the go.

- Suggestion 2: Getting myself ready

Using magnets, a photo of the child, and photos of items the child needs to move from one activity to the next, this visual support will help the child mentally and physically prepare before moving on to another activity. The main part of this board is a photo of the child. The smaller items that will be used as cards are things that the child will need to get ready for the next activity. If the child is getting ready to leave the house the cards should be things like shoes, a jacket (depending on the weather), a backpack, or a hat. First, prompt the child to move the shoes onto the larger photo. Then, have the child go get his or her own shoes and put them on. Repeat this process for each item until they have all been gathered by the child. The board makes this an interactive visual support and the child will eventually learn the sequence of getting ready to leave the house without being told!

Tips for Making Visual Supports

- Cover backing boards and cards with contact paper or lamination to increase durability and make any possible messes easy to clean up. Visual supports for bathtime can use cards in plastic bags attached to suction cups. Get creative; there is no right or wrong!
- Use Velcro on boards and cards so that they can be applied to different activities. Magnets can be used on a baking sheet or refrigerator, and snaps can be used to work on your child's fine motor skills as well.
- Extra cards can be stored in empty plastic peanut butter jars or baby wipe containers.
- Make statements in terms of what you *want* to see in the behavior, not what you already see.
- Use bright colors to appeal to children's senses. Using rhymes will help children commit things to memory.
- Use felt, crumpled tissue paper, or other materials to create a texture on the cards. Younger children will be drawn to the way different cards feel and may attend to them more than if they were simply paper. Experiment to find what your child likes!
- Include words with all pictures so that all adults using the visual support with your child will use the same words each time.
- If your child is bilingual you can put both languages on the cards—simply use different color ink for each language.
- If your child has a favorite cartoon character try to incorporate them into the pictures you use for your visual supports. This will turn your child's attention to the visual support itself and help to teach the lesson more quickly.
- If using photos, use pictures of the children themselves doing the activity or routine to make the lessons more tangible.

The Implementation of Visual Supports

When first introducing a visual support to your child stand behind him or her so as not to distract from the visual information being presented. Be sure to use only relevant language and help your child participate in the activity or routine. In the beginning it will be helpful to prompt your child, but those prompts should be lessened as time goes on so that your child comes to rely on the support for information rather than an adult.

In order for visual supports to be useful to your child the supports must be used consistently within an activity or routine for at least one week. This will teach children to associate the support with that activity or routine and eventually stop relying on the support over time. Additionally, visual supports for an activity or routine should be used across different settings so that your child will learn to generalize the lessons being taught. For instance, use a first then board while eating dinner at home, but also use it when eating in a restaurant or at grandma's house.

While using the visual support it is important to monitor your child's level of independence in the task. This will tell you if you are using the appropriate visual support for your child's needs. It will also help you track progress in meeting goals for your child's development and behavior.

Helpful Links:

http://tnt.asu.edu/tnt-helpdesk

The Tots-n-Tech helpdesk offers suggestions for how to make AT devices, including visual supports, for a variety of different activities and routines that may be challenging for children. New ideas are constantly being added!

http://www.challengingbehavior.org/index.htm

TACSEI provides parents, providers, and teachers with research-based strategies to improve the functioning of children. You can find free presentations, articles, and ideas that can be immediately applied.

http://csefel.vanderbilt.edu/

CSEFEL provides resources for families, teachers, and trainers in early intervention. Although many of their visual support materials are aimed toward children in childcare, they are easily adaptable to the home.

https://ccids.umaine.edu/resources/visual-supports/

This website offers a visual supports checklist that gives ideas to consider before creating a visual support for your child. There are also many links that give more background on visual supports and tips for making visual supports.

http://www.do2learn.com/

Provides free materials and tips on how to get started using visual supports with your child.

http://autismpdc.fpg.unc.edu/content/visual-supports

An overview of visual supports along with step by step instructions on how to make choice boards, visual schedules, and first then boards.

http://www.mayer-johnson.com/boardmaker-software/

Software with a variety of pictures for the activity cards that can be used with any of the visual supports discussed in this newsletter.

Please feel free to forward this newsletter to any individuals or agencies that may benefit from information on assistive technology.
Questions? Comments? Want to have the newsletter sent directly to your inbox?
Email Livia at livia.fortunato@jefferson.edu

Arizona State University - **Tots-n-Tech E-Newsletter,** October 2012 - Thomas Jefferson University

Indiana's Infant Mental Health Endorsement

The Indiana Infant Mental Health Endorsement is a proven competency-based process that coordinates across all systems—including mental health, child care, early intervention, and home visiting. If you are a First Steps provider, you are already specialist in birth to three years. Regardless of your discipline, chances are that your expertise includes knowledge of early childhood social and emotional development, the importance of early relationships for other areas of development, and skills and competencies needed to support parent-infant or parent-toddler relationships, then Indiana Infant Mental Health Endorsement may be right for you.

Three Reasons to Consider Indiana's Infant Mental Health Endorsement…

1. Earning Endorsement informs others of your professional competence.

Some participants have described themselves as "experience rich and credential poor". Endorsement provides a way for any professional who works with families and young children to showcase their professional accomplishments—including education, work experience, and supervision. Earning the Endorsement indicates to others that you have attained a high level of expertise and competence in your work with babies, toddlers and families.

2. Endorsement supports your ongoing professional development.

Each year you attend many different conferences, workshops, and in-service training events. Participating in the Indiana Endorsement can help you to identify training experiences that diversify and enhance your knowledge while leading to the credential. By using the Competencies to help identify your training needs, you will discover many aspects of early childhood work you may not have considered before!

3. Earning Endorsement helps you connect with other early childhood specialists.

Indiana is one of 14 states to adopt this Endorsement process. We are part of a larger group, the League of States, that shares ideas related to research, training, and work with children and families. When you join the Endorsement process, you also become a member of the Indiana Association for Infant and Toddler Mental Health, allowing you to attend our conference at a lower rate, and to receive our electronic newsletter, *Reflections*, as well as information from our parent organization, Mental Health America Indiana.

How does it work?

Endorsement can be earned at four levels so that individuals from associate to doctoral degrees may participate. People with many professional backgrounds may be eligible for Endorsement, including professionals from home visiting programs, child care, education, health professionals, mental health workers, and others. To become Endorsed a person prepares a portfolio documenting their education, work experience, training, and reflective supervision (for Levels 2-4), related to social and emotional health of babies and toddlers. Applicants must also submit additional materials including references and for Levels 3 and 4 pass a written examination. Support is available from the IAITMH to select a level, prepare a portfolio, and to study for the examination.

I'm interested -- What's my next step?

It's easy. Simply go to the Indiana Association for Infant & Toddler Mental Health website (http://iaitmh.org) and look under the Endorsement tab. Here you will find a preliminary application. **Right now we have funding to pay for applications for Healthy Families and other Early Intervention workers!** If eligible, your first year can be at no cost to you. **Have questions right now? We can help. Contact us at info@iaitmh.org.**

Indiana's Endorsement is supported by:

INDIANA Head Start State Collaboration Office

Sunny Start

INDIANA DEPARTMENT OF CHILD SERVICES

Indiana Association for Infant & Toddler Mental Health

1431 North Delaware Street

Indianapolis, IN 46202

(317) 638-3501 Ext. 228

http://iaitmh.org